

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15692

15687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>9736 5TH AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>C.</u> Last <u>NAYLOR</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-18</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABE CURELOP</u>		14. MOTHER'S MAIDEN NAME <u>Jannie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>FRANKLIN J. NAYLOR, See ITEM #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Carcinoma of oropharynx with glandular metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1750</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Nov 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 14</u> , 19 <u>67</u> , and that death occurred at <u>2:22</u> M, from causes on and the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Nov 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ETG</u>		22d. ADDRESS <u>86416 S. ...</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11-16-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Jos. Sawicki's Sons Inc.</u>		25a. REC'D BY REGISTRAR <u>Nov 20 1967</u>	
ADDRESS <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

12321

RECEIVED AT DEPT. OF AGRICULTURE

12321

U. S. DEPT. OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

RECEIVED

12321

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15693

CERTIFICATE OF DEATH

15688

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>4410 Franklin St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edmund M. Neary</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>Nov. 21</u> 19 <u>67</u> Month Day Year				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug. 6 1908</u> <u>59</u> yrs.		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>			
<b>13. FATHER'S NAME</b> <u>Edmund Neary</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Hazel Morris</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>135-09-5601</u>		<b>17. INFORMANT</b> <u>Mrs Ruth Neary</u> Address <u>Same as above</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture aneurysm, sacular</u> <u>451X</u> DUE TO <u>abdominal aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <u>arteriosclerosis</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 hrs.</u>  <u>Yrs</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> _____ (County) _____ (State) _____							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1957</u> , to <u>21 Nov. 1967</u> , that (I) <u>have</u> last saw the deceased alive on <u>21 Nov. 1967</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Horace Bernton</u> M.D.			<b>22b. DATE SIGNED</b> <u>11/22/67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Horace Bernton, M.D.</u>		
<b>22d. ADDRESS</b> <u>4743 Bradley Blvd.</u> <u>Chevy Chase, Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/25/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hollywood Cem.</u>			
<b>23d. LOCATION</b> (City or Town) <u>Union, New Jersey</u> (County) _____ (State) _____							
<b>24. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey</u> <u>Bethesda, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 27 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1888

CERTIFICATE OF DEATH

1888

The undersigned, *John A. Thompson*,  
 Minister of the Gospel,  
 do hereby certify that on the  
 10th day of *June*, 1888,  
 at *St. Louis, Mo.*,  
 departed this life  
*John A. Thompson*,  
 aged *40* years,  
 of the County of *St. Louis*,  
 State of *Missouri*.  
 Witness my hand and seal  
 this *10th* day of *June*, 1888.  
*John A. Thompson*  
 Minister of the Gospel

54

Robert A. Thompson  
 Minister of the Gospel  
 St. Louis, Mo.  
 John A. Thompson  
 Minister of the Gospel  
 St. Louis, Mo.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15694

15689

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>WASHINGTON</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN &amp; HOSP</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>3009 13th St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELEN D NORVILLE</b> First Middle Last 4. DATE OF DEATH <b>NOVEMBER 8 1967</b> Month Day Year		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>OCTOBER 30, 1898</b> 9. AGE (In years last birthday) <b>69</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b> 11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Dawley</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>579-56-7012</b> 16. SOCIAL SECURITY NO. <b>579-56-7012</b> 17. INFORMANT <b>MRS. EVA SMITH - DAUGHTER</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ventricular Fibrillation</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 22. DATE SIGNED <b>Nov. 9, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/15/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park</b> 23d. LOCATION (City or Town) (County) (State) <b>Landover PG MD.</b>		24. FUNERAL DIRECTOR <b>William W. Woodford</b> ADDRESS <b>1622 11th St. N.W., D.C. 20001</b> 25. REC'D BY REGISTRAR <b>NOV 14 1967</b> 26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



8 1 2  
6  
MAY 1967  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15690

15695

CERTIFICATE OF DEATH (Margaret J. O'Bree)

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P.R. GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON JAN. &amp; HOSP.</b>		d. STREET ADDRESS <b>401 BOYD AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>O'BREE</b> First <b>ANNA</b> Middle <b>MARGARET</b> Last <b>O'BREE</b>		4. DATE OF DEATH <b>NOVEMBER 5</b> 19 <b>67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 2, 1911</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED, Duty Bldg.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FEDERAL GOVT.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>TEXAS</b>
13. FATHER'S NAME <b>ORGIN JULIEN</b>		14. MOTHER'S MAIDEN NAME <b>MARY HOLCOMB</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSP. RECORDS.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA OF COLON</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-28-67</b> , 19 to <b>NOVEMBER 1967</b> , that (I) (two) last saw the deceased alive on <b>Nov. 3</b> 1967, and that death occurred at <b>5:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Morrill C. Quinnam Jr.</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-5-67</b>
22c. PHYSICIAN'S NAME (Type) <b>MORRILL C. QUINNAM, JR.</b>		22d. ADDRESS <b>831 UNIV. BLVD. E., SILVER SPRING, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE THEREOF <b>Nov. 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Whitehurst Texas</b>
24. FUNERAL DIRECTOR <b>North &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 8 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

cleared & medical examiner/L.S.

1998

NOT SUBMITTED

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Journal of Internal Medicine 247: 395–402

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15698

15691

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>                    </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>58 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>120 Oakland Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Ray Oldaker</u>				4. DATE OF DEATH Month Day Year <u>November 3 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 August 1948</u>		9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Oldaker</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Shelhammer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-70-5969</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 2043 DUE TO (b) <u>Gram Negative Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Acute Myelogenous Leukemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 Hours</u> <u>36 Hours</u> <u>12 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(A)</u> (this hospital) attended the deceased from <u>September 6, 19 67</u> , to <u>November 3 19 67</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>November 3 19 67</u> , and that death occurred at <u>7:55 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas P. Clancy</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Clancy, M. D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Nutter Fort, W. Va.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 9 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12323

12323

*James Clancy*

11-6-67

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Item 18-21 Film #395  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15692

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>3333 UNIVERSITY BLVD. #108</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUCY ANN OLMERT</b>		4. DATE OF DEATH <b>NOVEMBER 14 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1921</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eppa L. Norris</b>		14. MOTHER'S MAIDEN NAME <b>Sue Ginnavan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-22-8613</b>	
17. INFORMANT <b>William Norris</b>		18. ADDRESS <b>9505 Midwood Road Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure due</b> DUE TO <b>to Barbiturate Intoxication,</b> (b) <b>Apparently Self-administered</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased took overdose of Nembutal</b>	
20c. TIME OF INJURY Month, Day, Year <b>? Hour a.m. 11-14 1967 p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Kensington Mont Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		22. DATE SIGNED <b>Nov. 14, 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <b>Thomas B. Thomas</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles George</b>		25c. ADDRESS <b>84 Georgia Ave. Silver Spring, Md.</b>	

14251

Mathematics

Transcript

Washington University

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**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Place deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>7008 KENHILL RD</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN REAGAN OVERMAN</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-21</b>
9. AGE (In years last birthday) <b>45</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Research N.I.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Marietta, Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>I. J. Overman</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth BESSIE M SEEGAR</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife Natalie M. Overman</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		22. DATE SIGNED <b>Nov. 7, 1967</b>	
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-13-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gettysburg, Natl Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Gettysburg, Penna.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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EXHIBIT - 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="display: flex; justify-content: space-between;"> <span>15699</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>15694</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u> <u>901 Arcola Ave</u>						d. STREET ADDRESS <u>2016 Ogletowne Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Stewart</u> Last <u>Owen</u>						4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucas.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1/30/1893</u>		9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester, Mass.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ralph Edward Stewart</u>						14. MOTHER'S MAIDEN NAME <u>Nettie Jane White</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>265-14-6988 A</u>		17. INFORMANT <u>Priscilla Nakamura</u> Address <u>16133 Dewey Road Kensington, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reticulum cell Sarcoma</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>67</u> , to <u>11/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/5</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Myron L. Linkin</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/6/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Myron L. Linkin M.D.</u>						22d. ADDRESS <u>2309 Shorefield Road Wheaton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Central Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Malbury, Mass.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

15524

CERTIFICATE OF DEATH

15524

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

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CAUSE OF DEATH

DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
15700					15685					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8604 Springdell Place</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>8604 Springdell Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Nellie Teresa Owens</b> First Middle Last					4. DATE OF DEATH <b>November 29 1967</b> Month Day Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 30, 1878</b> Month Day Year		9. AGE (In years last birthday) <b>88</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Owens</b>					14. MOTHER'S MAIDEN NAME <b>Katie Tenley</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-50-0874</b>		17. INFORMANT <b>Louis G. Owens, Nephew, Same as #2</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO (b) <b>Coronary Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Generalized Arterio-sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>Unclear</b> <b>Unclear</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1934</b> to <b>Nov 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 25 1967</b> and that death occurred at <b>3:50 P.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>George L. Ball</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov 29, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>George L. Ball</b>						22d. ADDRESS <b>10620 Georgia Ave, Silver Spring, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/1/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Washington, D.C.</b> 5130 Wisconsin Ave, NW						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>DEC 4 1967</b>										

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Items 18&21 Film 396

12-18-67 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15701

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15696

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookeville</b> 15.1		d. STREET ADDRESS <b>RFD#1, Box 4D</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR ALBERT PACK, Jr.</b>		4. DATE OF DEATH Month Day Year <b>November 27 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1916</b>
9. AGE (In years lost birthday) <b>51 57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mfgs. Representative</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Albert Pack</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Burton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-01-0980</b>	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery heart disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b>		22. DATE SIGNED <b>Nov. 27 1967</b>	
EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-29-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodside</b>		23d. LOCATION (City or Town) (County) (State) <b>Brinklow Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15697

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1	
c. LENGTH OF STAY IN 1b <u>16 DAYS</u>		d. STREET ADDRESS <u>9314 WIRE AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM + HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES ADELAIDE PARKER</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 12 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1878</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>FREDERICK R. SMITH</u>		14. MOTHER'S MAIDEN NAME <u>? FRANCES TAYLOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>GORDON S. PARKER - SON - SILVER SPRING, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia C.V.A. - Hip fracture 16 days before</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fall at Home on 10-24-67</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at Home on 10-24-67</u>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <u>10-24-67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Silver Spring Mont. MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> , 19 <u>67</u> to <u>11-12</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-12</u> 19 <u>67</u> , and that death occurred at <u>10:23 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. W. McRoberts</u>		22b. DATE SIGNED <u>11-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. McRoberts, M.D.</u>		22d. ADDRESS <u>1400 Spring St S.S. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or town) (County) (State) <u>ARLINGTON, VA.</u>
24. FUNERAL DIRECTOR <u>Joseph Goulersons, Inc. Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Rep notified and approved

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15703

Item #4 Film #G395 11/30/67 pb

CERTIFICATE OF DEATH

15698

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>39 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 15-1 d. STREET ADDRESS <u>7513 Maple Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edith (NMN) Parsons</u> First Middle Last 4. DATE OF DEATH <u>Nov. 20 19 67</u> Month Day Year				5. SEX <u>Fe</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 20 1896</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired school teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Newfoundland Canada</u> 12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13. FATHER'S NAME <u>Adolphus Yates</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Moores</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>089-22-6832</u> 17. INFORMANT <u>Med. Record</u> Address <u>W.S.H.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive CVA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Generalized Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan 65</u> , 19 <u>65</u> , to <u>Nov 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 19</u> , 19 <u>67</u> , and that death occurred at <u>2:20 PM</u> , from causes and on the date stated above. 22a. SIGNATURE <u>R. H. Sandstrom M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/20/67</u> 22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u> 22d. ADDRESS <u>7201 Carroll Ave Takoma Park Md</u>			
23a. BURIAL-CREATION, REMOVAL (Specify) 23b. DATE THEREOF <u>Jan 24 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash Cemetery</u> 23d. LOCATION (City or town) (County) (State) <u>Capitol Hill F. Geo. Md</u>				24. FUNERAL DIRECTOR <u>Charles Judge</u> ADDRESS <u>254 Carroll St. NW</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>NOV 24 1967</u>			

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DEPARTMENT OF HEALTH

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MADE IN U.S.A. BY THE U.S. GOVERNMENT PRINTING OFFICE: 1964 O - 348-000

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

## CERTIFICATE OF DEATH

15704

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY in 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>1515 EXETER ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY BENJAMIN PARSONS</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 8 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-05</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADMINISTRATIVE ASSISTANT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>JOHN PARSONS</u>		14. MOTHER'S MAIDEN NAME <u>DUNN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes W.W.II</u>		16. SOCIAL SECURITY NO. <u>579 58 3007</u>	
17. INFORMANT <u>PATIENT'S CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>21 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleural Effusion, Bronchial Pneumonia, Hypoalbuminemia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>10-19-1967</u> , to <u>11-8, 1967</u> , that (1) (we) last saw the deceased alive on <u>11-8-1967</u> , and that death occurred at <u>12:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alan R. Gair</u>		22b. DATE SIGNED <u>11-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALAN R. Gair M.D.</u>		22d. ADDRESS <u>7777 Maple Ave, Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll, 21201 Wash D.C.</u>		25. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15700

15705

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>9119 Marseille Dr.</i>	
3. NAME OF DECEASED (Type or print) First <i>Maude</i> Middle <i>M</i> Last <i>Penn</i>		4. DATE OF DEATH Month <i>11</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-29-1879</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Horace Murphy</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Thompson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Daughter</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pyelonephritis chronic</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-20</i> , 19 <i>67</i> , to <i>11-28</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-28</i> , 19 <i>67</i> , and that death occurred at <i>8p</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. Daddario</i>		22b. DATE SIGNED <i>11/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDARIO</i>		22d. ADDRESS <i>5413 CEDAR LANE BETHESDA</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-1-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cath. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>DEC 4 1967</i>	

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CERTIFICATE OF DEATH

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*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15706				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15701			
Item #2b Film #0395 12/1/67				CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN Tb <b>6 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b> <b>06.2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home for the Aged, Inc.</b>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>May</b> Last <b>Pickett</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>26</b> Year <b>19 67</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Dec. 24, 1871</b>		9. AGE (In years last birthday) <b>95 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County, Maryland</b>			
13. FATHER'S NAME <b>Joseph James Brandenburg</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Dronenburg</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-54-7947-T</b>				17. INFORMANT Address <b>Asbury Methodist Home, Gaithersburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>5 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>3/1/63</b> , 19__ to <b>11/26/67</b> , 19__, that (I) (we) lost saw the deceased alive on <b>11/24/67</b> , and that death occurred at <b>1245P</b> M, from causes and on the date stated above.											
22a. SIGNATURE <b>Henry C. Seervogels MD</b>				22b. DATE SIGNED <b>11/26/67</b>							
22c. PHYSICIAN'S NAME (Type) <b>HENRY C. SEERVOGELS MD</b>				22d. ADDRESS <b>5413 Cedar Lane Bethesda Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-28-67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>			
23d. LOCATION (City or Town) (County) (State) <b>Woodbine Md.</b>											
24. FUNERAL DIRECTOR <b>John H. Sandison</b>				25a. REC'D BY REGISTRAR <b>John H. Sandison</b>				25b. REGISTRAR'S SIGNATURE <b>John H. Sandison</b>			
DATE <b>NOV 28 1967</b>											

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15707

CERTIFICATE OF DEATH

15702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington</u> 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5331 42nd. St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Frost</u> Last <u>Pierdon</u>		4. DATE OF DEATH <u>Nov. 8</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electroplater</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal Finishing</u>	11. BIRTHPLACE (County & State, or foreign country) <u>London, England</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1898</u>		16. SOCIAL SECURITY NO. <u>578-03-3534</u>	
17. INFORMANT <u>Arthur G. Pierdon</u>		Address <u>5331 42nd. St. N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Papillary carcinoma, Urinary Bladder</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 30, 1967</u> , to <u>Nov 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 8, 1967</u> , and that death occurred at <u>6:54 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leo W. Curtis</u>		22b. DATE SIGNED <u>Nov. 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-11-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Cawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12702

MINISTRE DE LA SÉCURITÉ

12702

Le 12 mai 1968

Monsieur le Ministre

Monsieur le Ministre

Monsieur le Ministre

Monsieur le Ministre

Monsieur le Ministre

Monsieur le Ministre

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15708

CERTIFICATE OF DEATH

15703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

168  
Cleared by M.D. Egan

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY in 1b <u>19 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>8714-23RD AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHESTER</u> First Middle Last				4. DATE OF DEATH <u>11-19-67</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/8/1915</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVY DEPT WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY DEPT.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Plachta</u> (SITE PLANNER)				14. MOTHER'S MAIDEN NAME <u>Anna Gromny</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>134-12-6827</u>		17. INFORMANT <u>Eleanor M. Plachta</u> 8714 Address 23rd Avenue Adelphi, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>2000</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Reticulum Cell Sarcoma</u> DUE TO (c) <u>4 mos.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>67</u> , to <u>11/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/13</u> , 19 <u>67</u> , and that death occurred at <u>4:10 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>G. Leonard Gold</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>				22d. ADDRESS <u>9801 Georgia Avenue, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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January 3rd 1871



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15709

15704

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Md.</u>			c. LENGTH OF STAY in 1b <u>1 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			15-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant View Nursing Home</u>				d. STREET ADDRESS <u>5510 Lincoln Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>BOSWELL</u> Last <u>POOLE</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/1881</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Lawson Poole</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Boswell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-1970</u>		17. INFORMANT <u>Nephew</u> <u>W. R. Poole</u>		6013 <sup>Add</sup> <u>Berkshire Drive</u> <u>Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>tuberculosis, quiescent</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> — , 19 <u>67</u> , to <u>11-25-67</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>11-23</u> — 19 <u>67</u> , and that death occurred at <u>7:15 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Milton D. Westberg</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILTON D. WESTBERG M.D.</u>				22d. ADDRESS <u>431 N. Frederick Ave Gaithersburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County Md.</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR OATE <u>DEC 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15704

TESTIFICATE OF DEATH

15704

2510 Lincoln Street

11/11/1911

Washington, D. C.

Deceased

Next of Kin

Edward Scott

Edmund Scott

5015 - 15th Street  
Washington, D. C.

11-11-1911

Case of Edward  
Scott

11-11-1911

11-11-1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY MARYLAND				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				15705			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>151</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>10109 BRUNETT AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>R.</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>19</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/5/95</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Rolls</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>yes</u>				17. INFORMANT <u>Ernest G. Kieffer</u> <u>10109 Burnett Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE GASTRO-INTESTINAL HEMORRHAGE</u> DUE TO (b) <u>RUPTURED ESOPHAGEAL VARICES</u> DUE TO (c) <u>PORTAL CIRRHOSIS OF LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS</u> <u>6 HRS</u> <u>10+ YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>60</u> , to <u>NOV 19</u> , 19 <u>67</u> , that (I) <del>last</del> saw the deceased alive on <u>NOV 19</u> , 19 <u>67</u> , and that death occurred at <u>6:20 P.M.</u> from causes and on the date stated above.											
22a. SIGNATURE <u>Edward A. Beeman</u> M.D.				22b. DATE SIGNED <u>NOV 19, 1967</u>							
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>				22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING MD 20910</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>				23b. DATE THEREOF <u>Nov. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park, Inc.</u>		23d. LOCATION (City or Town) (County) (State) <u>New Orleans, La.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1978

1978

STATE OF OHIO

IN SENATE,  
January 10, 1978.  
REPORT  
OF THE  
COMMISSIONER OF  
THE  
DEPARTMENT OF  
REVENUE,  
FOR THE  
FISCAL YEAR  
ENDING  
JUNE 30, 1977.  
ASSEMBLED  
IN SENATE,  
January 10, 1978.  
PUBLISHED  
BY THE  
STATE OF OHIO,  
1978.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15711

15706

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN TB <u>6 mo.</u>		d. STREET ADDRESS <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA W. Pyles</u>		4. DATE OF DEATH <u>November 11 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-79</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montg. - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Sarah White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-48-8592</u>	
17. INFORMANT <u>Mrs. Riggs Darby Boyde, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of anus &amp; rectum</u> DUE TO (b) <u>154X</u> DUE TO (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe arteriosclerosis &amp; arterio-sclerosis - 5 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>Nov. 11</u> , 19 <u>67</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Nov 11</u> , 19 <u>67</u> , and that death occurred on <u>Nov 11</u> , 19 <u>67</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. A. Linthicum</u>		22b. DATE SIGNED <u>11/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. A. Linthicum</u>		22d. ADDRESS <u>110 S. Washington St. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Constance C. Hilton</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Barneville Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1871

REPUBLIC OF DENMARK

1871

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15712

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15707

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban.</u>		d. STREET ADDRESS <u>5108 Sardana Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Francis Arthur Pyles</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>47</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Arthur Pyles</u>		14. MOTHER'S MAIDEN NAME <u>Marie Shadler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother Marie S. Pyles</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, recent &amp; remote</u> DUE TO (b) <u>Coronary arteriosclerosis with occlusion</u> stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>11/22/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15713

**CERTIFICATE OF DEATH**

15708

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>6 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>13317 Bea Kay Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harland</b> Middle <b>Christopher</b> Last <b>Randolph</b>				4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 October 1967</b>		9. AGE (In years lost birthday) yrs. <b>1</b> Months <b>19</b> Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harland L. Randolph</b>				14. MOTHER'S MAIDEN NAME <b>Mariam Lawson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland</b> Address <b>20014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Atresia</b> <b>7590</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>21</b>		
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>November 15, 1967</b> , to <b>November 21, 1967</b> , that <del>it</del> (we) last saw the deceased alive on <b>November 21, 1967</b> , and that death occurred at <b>7:25 M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Willis H. Williams</b>				22b. DATE SIGNED <b>Nov. 22, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Willis H. Williams, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 11-23-67</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>4545 Mass. St. D.C.</b>	
24. FUNERAL DIRECTOR <b>Robert A. Moseley</b>				25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MINUTE OF COUNCIL

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25M 1/67

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CERTIFICATE OF DEATH

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Married

Single

Married

John Doe, Jr.

John Doe, Jr.

John Doe, Jr.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15715

Item #9 Film #G394 11/8/67 ph

Item #8 Film G394 11/10/67 kk

CERTIFICATE OF DEATH

15710

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>PR GEO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>			16-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>4655 Dupont Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Paul</b>		First Middle Last <b>Dana REED</b>		4. DATE OF DEATH <b>November 3 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1966 Jan. 21, 1967</b>	9. AGE (In years lost, birthday) <b>1 1/2 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>9 9 9 9</b>	IF UNDER 24 HRS. Months Days Hours Min. <b>9 9 9 9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ROTA, SPAIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raymond Reed</b>				14. MOTHER'S MAIDEN NAME <b>Mary Phillips</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Suitland</b> Address <b>Maryland</b> <b>POC Raymond Reed, USN, 4655 Dupont Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral</b> <b>733X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myeloproliferative disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (s) (this hospital) attended the deceased from <b>Nov. 2</b> , 19 <b>67</b> , to <b>Nov. 3</b> , 19 <b>67</b> , that (s) (we) last saw the deceased alive on <b>Nov. 3</b> 19 <b>67</b> , and that death occurred at <b>1108 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Jerry J. Tomasovic</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>AM</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-6-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Academy Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Evansville, Arkansas</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> <b>1400 Chapin Street, N.W., Washington, D.C.</b>				25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

15716

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15711

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>D.</b> Last <b>Reeley</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1911</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Reeley</b>				14. MOTHER'S MAIDEN NAME <b>Annie Navigan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Medical Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Disease.</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>11502 Grandview Ave. Wheaton, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-10-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bellevue Corner Md.</b>	
24. FUNERAL DIRECTOR <b>W. Witt Dannekean</b>				25a. RECEIVED BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>NOV 13 1967</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15717

15712

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland 20810</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>27 A Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Earl Ernest Rhodes</b>			4. DATE OF DEATH Month Day Year <b>November 28 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8-99</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>16-2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Race Tract Owner &amp; Horse trainer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>America</b>
13. FATHER'S NAME <b>Rhodes</b>			14. MOTHER'S MAIDEN NAME <b>Mary</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-18-2494</b>	17. INFORMANT <b>Patient's chart</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2924</b> IMMEDIATE CAUSE (a) <b>APLASTIC ANEMIA ; ASSOCIATED WITH</b> DUE TO <b>PNEUMONIA of RIGHT LUNG</b> (b) <b>AND LEUKOPENIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PELVIC ABSCESS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>2 wks +</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>11/14/67</b> , 19 <b>67</b> , to <b>11/28/67</b> , 19 <b>67</b> , that <del>he</del> we last saw the deceased alive on <b>11/28/67</b> , and that death occurred at <b>6:25</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Paul L. Robb M.D.</b>			22b. DATE SIGNED <b>11/28/67</b>		22c. PHYSICIAN'S NAME (Type) <b>PAUL L. ROBB, M.D.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12-1-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ing Hill Cem</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>			25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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RECORDS OF DEATH

DEPARTMENT OF HEALTH

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Paul A. Robb, m.d.

2500 Sprague Ave.

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RECORDS OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>8 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>808 Rowen Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>J.</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/92</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Produce Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.G.S. Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J. J. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Van Horn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>189-09-1415</u>	
17. INFORMANT <u>Mrs. Pete Morris</u>		18. ADDRESS <u>808 Rowen Road Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Poisoning</u> DUE TO (b) <u>Multiple Myeloma</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>approximately 1964</u> to <u>Nov. 6, 1967</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Nov. 6, 1967</u> , and that death occurred at <u>6:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen M.D.</u>		22b. DATE SIGNED <u>Nov. 6, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gene U. Cohen M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
23e. FUNERAL DIRECTOR <u>C. Glen Carter 8434 Georgia Avenue</u>		23f. DATE <u>NOV 10 1967</u>	
23g. ADDRESS <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		23h. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12712

CERTIFICATE OF DEATH

12712

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>1609 BELVADERE BLVD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAAD</u> First <u>RICHEY</u> Middle Last		4. DATE OF DEATH <u>NOV.</u> Month <u>20</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1896</u> 9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LEBANON, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Richey</u>		14. MOTHER'S MAIDEN NAME <u>S. Munghoon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>173-18-7951</u>	
17. INFORMANT <u>George Richey</u>		Address <u>1609 Belvedere Blvd. Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Metastases</u> 192x DUE TO (b) <u>Melanoma (Primary site, rt. eye)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>30+ yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1967, to <u>11/20</u> , 1967, that (I) (we) last saw the deceased alive on <u>11/19</u> , 1967, and that death occurred at <u>1:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>11/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>		22d. ADDRESS <u>9801 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sylvan Heights Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Uniontown, Pennsylvania</u>
24a. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15720

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15715

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				d. STREET ADDRESS <u>1 ERICSSON ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>HILBERT</u> Last <u>RICKETTS</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/08</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CORNELLS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID RICKETTS</u>				14. MOTHER'S MAIDEN NAME <u>MAUDE FISHER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>VIRGINIA RICKETTS - WIFE - SAME</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis - atherosclerosis</u> DUE TO (c) <u>Immediate</u> <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour: <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 29</u> , 19 <u>66</u> , to <u>Nov 7</u> , 19 <u>67</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Nov 7</u> , 19 <u>67</u> , and that death occurred at <u>906</u> AM, from causes on and on the date stated above.							
22a. SIGNATURE <u>Allen J. O'Neill</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>ALLEN O'NEILL</u>	
22d. ADDRESS <u>8601 Old Georgetown Rd. Bethesda, Maryland</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

C. 1.

1. The following are the names of the persons who have been  
 2. named in the above list of names:

Attorney General

53 5 54

15-1-1975

10





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

3

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15721

CERTIFICATE OF DEATH

15716

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>Route #3</u>	
3. NAME OF DECEASED (Type or print) First <u>Doris</u> Middle <u>Fern</u> Last <u>Romesberg</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 October 1921</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Simon Enos</u>		14. MOTHER'S MAIDEN NAME <u>Susan Liphart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not Available</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>20014 The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1909</u> IMMEDIATE CAUSE (a) <u>Metastatic Malignant Melanoma</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>30 October, 1967</u> , to <u>11 Nov., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11 November 1967</u> , and that death occurred at <u>7:55 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur J. Levine</u>		P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>Nov. 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur J. Levine, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rockwood IOOF</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockwood, Pa.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15751

NEW YORK, N. Y.

THE NEW YORK PUBLIC LIBRARY, ASTOR LENOX AND TILDEN FOUNDATIONS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15722 CERTIFICATE OF DEATH 15717

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>401 RANDOLPH B. (HOLY FAMILY SEMINAR)</u>				d. STREET ADDRESS <u>401 RANDOLPH B.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>(NMI)</u> Last <u>RUENSA</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 FEB 1883</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>CHURCH</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SPAIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-56-4701</u>		17. INFIRMANT <u>FATHER HOFFMAN</u> Address <u>401 RANDOLPH B S.E. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - diffuse</u> 4200 DUE TO (b) <u>Heart failure - congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Postcoronary heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>Months</u> <u>Yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old age - Rheumatoid arthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Nov 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 4</u> , 19 <u>67</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard P. Delaney</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY, MD</u>	
22d. ADDRESS <u>4323 HARVARD ST. SIL. SPR. MD.</u>				22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8 NOV. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City, town or county) (State) <u>SILVER SPRING MD.</u>	
24. FUNERAL DIRECTOR <u>PINAKI FUNERAL HOME INC. HOODS CIRCLE N.W. 20012</u>				25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1937

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1937-1938



CHIEF OF BUREAU

1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15723		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		17349	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>8104 Hampden Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charlotte F. Ruppert</u> First Middle Last 4. DATE OF DEATH <u>Nov. 29 19 67</u> Month Day Year				5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>7 Sept 1892</u> 9. AGE (In years last birthday) <u>75</u> yrs. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick J. Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Brady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patricia R. Nelson</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO <u>Primary duct carcinoma, right breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>2 years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-29</u> , 19 <u>67</u> to <u>11-29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-29</u> 1967, and that death occurred at <u>6:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Geo. A. Gray, Jr.</u> M.D.		22b. DATE SIGNED <u>Nov 30 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>GEORGE A. GRAY, JR.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1875

1894

810 + 110 = 920

2218

Thomson

Robert D. Thompson

James D. Smith

1. *Chrysomelidae* (100)



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARRETT PARK</u>	
c. LENGTH OF STAY IN lb <u>DOA</u>		d. STREET ADDRESS <u>10904 Montrose Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>DEPORRES</u> Last <u>Russillo</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1964</u>
9. AGE (In years lost birthday) <u>3 yrs.</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u> Hours <u>1</u> Min. <u>15-1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul D. Russillo</u>		14. MOTHER'S MAIDEN NAME <u>Castroada, Angela</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Paul Russillo - father (add name)</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>351X Aspiration of Gastric Contents</u> DUE TO (b) <u>Cerebral Palsy</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>34 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <u>—</u> of work <u>—</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>11/27/67</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Nov. 29, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Providence, Rhode, Island</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 1 1967</u>	

12718

12718

DEC 1 1967

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G305 11/24/67 KK

## CERTIFICATE OF DEATH

15725

15719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville - Rural</u>	
c. LENGTH OF STAY in 1b <u>7 yrs</u>		d. STREET ADDRESS <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>St. Laurent</u> Last <u>St. Laurent</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1876</u> 9. AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leon St. Laurent</u>		14. MOTHER'S MAIDEN NAME <u>Helia Lessard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs. Laurence O'Brien</u>		Address <u>Poolesville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Bronchitis and Pulmonary Emphysema</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis and Pulmonary Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October, 1962</u> , to <u>14 Nov, 1967</u> , that (I) (we) last saw the deceased alive on <u>14 Nov 1967</u> , and that death occurred at <u>9:45P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gordon Murdoch Smith</u>		22b. DATE SIGNED <u>14 Nov 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon Murdoch Smith</u>		22d. ADDRESS <u>Barnesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/17/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cath.</u>	23d. LOCATION (City or town) (County) (State) <u>Barnesville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Constance C. Hilton</u>		25a. REC'D BY REGISTRAR <u>NOV 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15725

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15720

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN TB <u>6 mos - 8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>4856 Chevy Chase Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>H.</u> Last <u>Sasscer</u>				4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-91</u>		9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.-Gen. Acct. Office</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>H. H. Sasscer</u>				14. MOTHER'S MAIDEN NAME <u>Lieze Fitch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>			16. SOCIAL SECURITY NO. <u>220-42-1488</u>		17. INFORMANT Address <u>Harrison Sasscer, Son, Same as #2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Left hemiplegia</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 2</u> , 19 <u>67</u> , to <u>Nov 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> , 19 <u>67</u> , and that death occurred at <u>8:30 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr Joseph Kenrick</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR JOSEPH KENRICK</u>				22d. ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Croom, Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph Yaulers Son Lexington Dc</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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RECORDS OF THE DISTRICT OF COLUMBIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #G395 12/1/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> D.C. b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> Wash., D.C. <u>47-3</u>		d. STREET ADDRESS <u>615 Que St., N.W. Cairo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Health Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>A.</u> Last <u>Schellhase</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Nov 19, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Evansville, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gus Schellhase</u>		14. MOTHER'S MAIDEN NAME <u>Louise Mundy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Kriehaus-Sansom Funeral Home</u> <u>702 Gum Street, Evansville, Indiana</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>63</u> , to <u>PRESENT</u> , 19 <u>  </u> , that (I)(we) last saw the deceased alive on <u>Nov 18</u> 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis Chucker</u>		22b. DATE SIGNED <u>11-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS CHUCKER MD</u>		22d. ADDRESS <u>2500 CALVERT ST NW WASH, DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Evansville, Indiana</u>	
24. FUNERAL DIRECTOR <u>JB Thomas</u> <u>8434 Georgia Ave.</u> <u>Arner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REGD. BY REGISTRAR <u>NOV 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15728

**CERTIFICATE OF DEATH**

15722

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>6905-Granby St.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Emma</u> Middle <u>M.</u> Last <u>Schmueser</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/30/88</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Leonard Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Julia Posselt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-2638</u>		17. INFORMANT Address <u>Same as Item 2.</u> <u>Mrs. Herman Gaines</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Hypertension - Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>19 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis, severe</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Sept. 19, 1958</u> to <u>Nov. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 10, 1967</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Angle</u>				22b. DATE SIGNED <u>Nov. 10, 1967</u>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>				22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hammond, Indiana</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
15723									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN b <b>1571</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>8201 16th ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ETHEL C. SCHOOLER</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1967</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-31-09</b>		9. AGE (In years lost birthday) <b>58</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Morris Cohen</b>				14. MOTHER'S MAIDEN NAME <b>Celia</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>--</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Myron I. Weinstein - 12015 Cold Stream Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>330X</b> IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> DUE TO (b) <b>Ruptured saccular intracranial aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>9 days</b>								INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>67</b> to <b>11/4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/3</b> , 19 <b>67</b> , and that death occurred at <b>2:25 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>John Thomas Lord</b>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <b>John Thomas Lord</b>	
22d. ADDRESS <b>1015 Spring St Silver Spring, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <b>1015 Spring St Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMQVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-5-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Shalom Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hillside Maryland</b>		23e. REC'D BY REGISTRAR <b>NOV 8 1967</b>	
24. FUNERAL DIRECTOR <b>Bernard Danzky AND sons</b>				24a. ADDRESS <b>Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

13323

CERTIFICATE OF DEATH



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15730

**CERTIFICATE OF DEATH**

15724

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>3438 Chiswick Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Henry</u> First <u>Schultheis</u> Middle Last <b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>20</u> Year <u>1967</u>			<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2/3/199</u> <b>9. AGE</b> (In years lost birthday) <u>68</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Architectural Engineer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Engineering</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Anton Schultheis</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Louisa Gossweiler</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>226-26-0198-A</u> <b>17. INFORMANT</b> <u>Elizabeth Schultheis</u> Address <u>3438 Chiswick Ct. Silver Spring, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X METASTATIC CEREBRAL CA</u> DUE TO (b) <u>METASTATIC PULMONARY CA.</u> DUE TO (c) <u>CARCINOMA - PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>6-8 weeks</u> <u>12 weeks</u> <u>?</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10/26</u>, 19<u>67</u>, to <u>11-19</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>11/19</u>, 19<u>67</u>, and that death occurred on <u>11/20</u> AM, from causes on and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Francis C. Mayle Jr.</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>FRANCIS C. MAYLE JR</u>		<b>22b. DATE SIGNED</b> <u>11/20/67</u> <b>22d. ADDRESS</b> <u>8218 Wisconsin Ave Bethesda</u>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Transit</u> <b>23b. DATE THEREOF</b> <u>Nov. 24, 1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Flushing Cemetery</u> <b>23d. LOCATION (City or Town) (County) (State)</b> <u>Flushing, New York</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>DATE</b> <u>NOV 24 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b>			

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CENTRALE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15731

CERTIFICATE OF DEATH

15725

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. SITE <u>The Army Listaff Hall</u> <u>6200 Oregon Ave., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>L.</u> Last <u>Seaman</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years) <u>86</u> yrs.
9. DATE OF BIRTH <u>7/30/81</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver C. Look</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Beedle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>131-24-4708</u>	
17. INFORMANT <u>Jonathan Seaman - Ft. Meade, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> <u>Branchopneumonia</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> , 19 <u>67</u> , to <u>11/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> , 19 <u>67</u> , and that death occurred on <u>11/26</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Myron L. Lenkin</u>		22b. DATE SIGNED <u>11/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Myron L. LENKIN MD</u>		22d. ADDRESS <u>2307 SHOREFIELD RD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Shirley S. Hines</u>		ADDRESS <u>2901-14th</u>	
25a. REC'D BY REGISTRAR <u>Charles Jones</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
DATE <u>NOV 30 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15732

CERTIFICATE OF DEATH

15726

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill, Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium + Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Bertha</u> Last <u>Saitz</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1897</u>		9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Europe, Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Julius Koblenz</u>			14. MOTHER'S MAIDEN NAME <u>Marie Godot</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <u>Carl Saitz Husband same as #2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Several Weeks</u> <u>Several Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatoid Arthritis, Cushing Syndrome from Long Term Corticosteroids</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1967, to <u>November 28</u> , 1967, that (I) (we) last saw the deceased alive on <u>November 28</u> 1967, and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Stuart L. Nelson</u>			22b. DATE SIGNED <u>11-28-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>			22d. ADDRESS <u>831- Univ. Blvd. East Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 1st, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill, Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>			25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15733

15727

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>33 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 Suburban Hospital</u>				d. STREET ADDRESS <u>604 MONROE ST. Apt 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARTHA</u> Middle <u>LOLA</u> Last <u>SEXTON</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>11</u> Year <u>1967</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <u>12/28/07</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>59</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ANIMAL CARETAKER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N/A</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>VIRGINIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>LARK WILLIS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>OLIE BOWEN</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-30-1171</u>		<b>17. INFORMANT</b> <u>1403 LANGBROOK PLACE - ROCKVILLE MD</u> <u>EDITH LEWIS DAUGHTER</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism with infarction</u> <u>297X</u> DUE TO (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Myelodysplasia</u>						INTERVAL BETWEEN ONSET AND DEATH  	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Myelodysplasia disorder</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B.)  					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour _____ a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  		<b>20f. (City or town) (County) (State)</b>  	
<b>21. I certify that (this hospital) attended the deceased from</b> <u>OCT 9, 1967</u> , to <u>11/11, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/10, 1967</u> , and that death occurred at <u>5:30 AM</u> , from causes on and on the date stated above.							
<b>22a. SIGNATURE</b> <u>J. Daniel Wilkes</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>  	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>J. Daniel Wilkes</u>				<b>22d. ADDRESS</b> <u>6405 Winston Drive, Bethesda, Maryland</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/13/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Rockville, Maryland</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 Rockville Pike, Rockville, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>NOV 14 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

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*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "received" and "paid" are faintly visible.]*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5805 LONE OAK DRIVE</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. STREET ADDRESS <b>5805 LONE OAK DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARGARET M. SHADA</b> First Middle Last			4. DATE OF DEATH <b>Nov. 19 1967</b> Month Day Year		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 31, 1920</b>	9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John Murtagh</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth MacLear</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Husband</b> <b>John Shada</b> Address <b>Same as Item 2.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary thrombosis, descending branch, left sudden</b> DUE TO (b) <b>Advanced coronary arteriosclerosis</b> DUE TO (c) <b></b> Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Md.</b>		22. DATE SIGNED <b>Nov 20, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Md.</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b> ADDRESS			25a. REC'D BY REGISTRAR DATE <b>NOV 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15735

15729

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>		
c. LENGTH OF STAY IN 1b <b>12325 New Hampshire Ave.</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Colonial Villa Nursing Home</b>			d. STREET ADDRESS <b>3701 16th St. N.W.</b>		
3. NAME OF DECEASED (Type or print) <b>Miss Mary E. Shearer</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1967</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/2/83</b>		9. AGE (in years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>David Shearer</b>			14. MOTHER'S MAIDEN NAME <b>Anna V. Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>579-66-2850</b>		17. INFORMANT <b>William T. Wolfrey</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial thrombosis Rleg</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 23</b> , 19 <b>67</b> , to <b>Nov 28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-23</b> , 19 <b>67</b> , and that death occurred at <b>11:04</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Bennie G. Bendlar</b>			22b. DATE SIGNED <b>11-28-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Bennie G. Bendlar</b>			22d. ADDRESS <b>10820 GA. Ave. Wheaton, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>11/30/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>	
23d. LOCATION (City, town or county) <b>Prince Georges County, Md</b>		(State)			
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>			25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
2901 14th St. N.W. Washington, D.C.					

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CERTIFICATE OF ADOPTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15738

15730

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nottingham		75-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20014 The Clinical Center, Bethesda, Maryland			d. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Tony Jay Sheets			4. DATE OF DEATH Month Day Year November 14 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 April 1965		9. AGE (In years lost birthday) 2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Jessie Sheets, Jr.			14. MOTHER'S MAIDEN NAME Katherine L. Cochran		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 DUE TO (b) Subcutaneous hemorrhage at tracheostomy site DUE TO (c) Brainstem compression and displacement by tumor PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mass					INTERVAL BETWEEN ONSET AND DEATH 4 months minutes ---
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from November 14, 19 67, to November 14, 19 67, that (X) (we) last saw the deceased alive on November 14, 19 67, and that death occurred at 8:10M, from causes and on the date stated above.					
22a. SIGNATURE Paul P. Carbone M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> PM		22b. DATE SIGNED 1967 15 November	
22c. PHYSICIAN'S NAME (Type) Paul P. Carbone, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/16/67		23c. NAME OF CEMETERY OR CREMATORY Britain Presbyterian	
				23d. LOCATION (City or Town) (County) (State) Peach Bottom R.D. Lancaster County, Pa.	
24. FUNERAL DIRECTOR The S.H. Hines Co.		25a. REG. BY REGISTRAR DATE NOV 20 1967		25b. REGISTRAR'S SIGNATURE James Judge	
2901 14th St. N.W. Washington, D.C.					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY										PRINCE GEORGE COUNTY									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND										2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLLEGE PARK</b>									
c. LENGTH OF STAY IN 1b <b>DOA</b>										d. STREET ADDRESS <b>TO MARYLAND AVE</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN + Hosp.</b>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>BRUCE EDGAR SHEPLEY</b>										4. DATE OF DEATH <b>11 5 1967</b>									
5. SEX <b>MALE</b> 6. COLOR OR RACE <b>W</b>										7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <b>Jan. 13, 1917</b>										9. AGE (In years last birthday) <b>50</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LENS GRINDER</b>										10b. KIND OF BUSINESS OR INDUSTRY <b>Chapel Optical Co.</b>									
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>										12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Edgar Shepley</b>										14. MOTHER'S MAIDEN NAME <b>Lulu Marker</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>										16. SOCIAL SECURITY NO. <b>215-16-9135</b>									
17. INFORMANT <b>Mrs. Eleanor Shepley</b>										18. ADDRESS <b>To Md. Ave. College Park, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary embolism secondary to</b> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>fractured right os calcis due to</b> DUE TO (c) <b>fall.</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased fell at home fracturing right heel</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9-3</b> p.m. <b>19 67</b>										20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>										20f. (City or town) (County) (State) <b>College Park Pr. Geo. Md.</b>									
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.										22. DATE SIGNED <b>Nov. 5, 1967</b>									
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (City or town) (County) <b>Washington</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE THEREOF <b>Nov. 8, 1967</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>										23d. LOCATION (City or town) (County) (State) <b>Frederick, Fred Co. Md.</b>									
24. FUNERAL DIRECTOR <b>Paul F. Bittle, Myersville, Md.</b>										25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>									
										25b. REGISTRAR'S SIGNATURE <b>William Judge</b>									

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MARYLAND STATE DEPARTMENT OF HEALTH

15738

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CHEVY CHASE NURSING &amp; CONV. CENTER</u>		d. STREET ADDRESS <u>8211 14th AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>AKIHI</u> Middle <u>O.</u> Last <u>SHIROISHI</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>YELLOW</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-87</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>JAPAN</u>
12. CITIZEN OF WHAT COUNTRY? <u>JAPAN</u>		13. FATHER'S NAME <u>OKAMATSU</u>	
14. MOTHER'S MAIDEN NAME <u>NOT AVAILABLE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MISS TSUGIYE SHIROISHI (Same as #2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1966</u> , 19 <u>67</u> to <u>11/8</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>11/4</u> , 19 <u>67</u> , and that death occurred at <u>1:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Morton Shapiro</u>		22b. DATE SIGNED <u>11/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORTON SHAPIRO</u>		22d. ADDRESS <u>8107 EASTERN AVE, SILVER SP. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>Nov. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREMATORY</u>	23d. LOCATION (City or Town) (County) (State) <u>COLUMMAR MANOR MD</u>
24. FUNERAL DIRECTOR <u>Charles Jones</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

1873

REPUBLICAN OF DEATH

1873

A LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15733

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>11510 - Reginal Drive</u>	
3. NAME OF DECEASED (Type or print) <u>David H. Shober</u>		4. DATE OF DEATH <u>Nov 7 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>People's Drug</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Shober</u>		14. MOTHER'S MAIDEN NAME <u>Mary Baltz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-30-832</u>	
17. INFORMANT <u>ARNITA C. David Shober</u>		Address <u>See Item #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>esophageal varices</u> DUE TO (c) <u>cirrhosis, liver</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26, 1967</u> to <u>Nov. 7, 1967</u> that (I) (we) last saw the deceased alive on <u>Nov 7, 1967</u> , and that death occurred at <u>4 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rabert J. Shober</u>		22b. DATE SIGNED <u>11-8-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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• **4551**

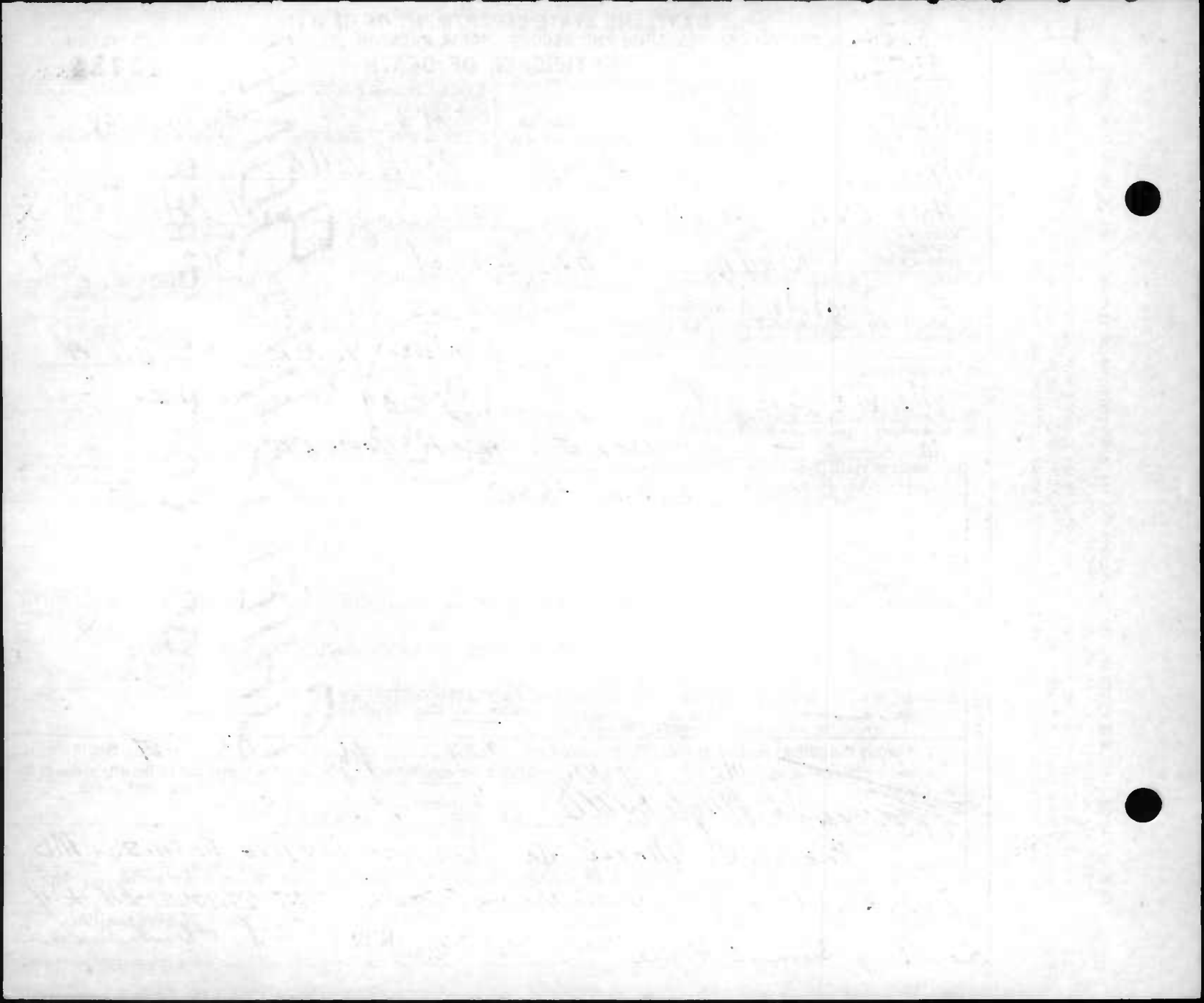
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15740 CERTIFICATE OF DEATH 15734

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>263 Congressional Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Randi</b> First <b>B.</b> Middle <b>Siegel</b> Last		4. DATE OF DEATH <b>11</b> Month <b>14</b> Day <b>1967</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-57</b> 9. AGE (In years last birthday) <b>9 1/2</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Marvin Siegel</b>	
14. MOTHER'S MAIDEN NAME <b>NORMA RACKOWITZ</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSP. RECORDS</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>237X IMMEDIATE CAUSE (a) Brain tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 19 <b>66</b> , to <b>11/14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/13</b> , 19 <b>67</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Francis C. Matyle Jr</b> 22c. PHYSICIAN'S NAME (Type) <b>FRANCIS C. MATYLE JR</b>		22b. DATE SIGNED <b>NOV 16 1967</b> 22d. ADDRESS <b>8218 WISCONSIN AVE BETHESDA MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW MONTEFIORE CEM</b>	23d. LOCATION (City, town or county) (State) <b>FARMINGDALE L.I., NY.</b>
24. FUNERAL DIRECTOR <b>Holberg Funeral Home</b> ADDRESS <b>4212 9th St. N.W.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1967</b> 25b. REGISTRAR'S SIGNATURE <b>William Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15741

15735

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Filed with Dr. Goldenhop, Corner of Foster & David, Hager*

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. &amp; HOSP.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> d. STREET ADDRESS <u>6718 WEST PARK DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>(N.M.N.)</u> Last <u>SINITZ</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 20, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ISADORE CHEDAKOV</u>				14. MOTHER'S MAIDEN NAME <u>  </u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>076-03-9186</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis with myocardial infarct</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis of the coronary blood vessels</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>		
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>65</u> , to <u>Nov 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 14, 1967</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Sydney Leventhal</u> M.D.				22b. DATE SIGNED <u>11/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>	
22d. ADDRESS <u>Silver Spring, Md.</u>		22e. <u>  </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>			
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>		ADDRESS <u>232 Carroll</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
HEBREW MEMORIAL FUNERAL HOME		STREET, N. W.		DATE <u>NOV 21 1967</u>			
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15742

Item #4 & 21 Film #G391 11/16/67 ph

CERTIFICATE OF DEATH

15736

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>4-WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>1004 CARSON ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>MOSES</u> Last <u>SITES</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-05</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Library Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publications</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Achim W. Sites</u>				14. MOTHER'S MAIDEN NAME <u>Ruhoma Jenkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Geraldine B. Sites</u>		Address <u>1004 Carson Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Acute left anterosseptal myocardial infarction</u> (b) <u>Thrombosis ant. des. branch, left cor. artery</u> DUE TO <u>A.S.H.D.</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/9/67</u> to <u>11/3/67</u> , that (I) (we) last saw the deceased alive on <u>11/3/67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John J. Curry M.D.</u>				22b. DATE SIGNED <u>11/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sites Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Grant County, West Virginia</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25c. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15743

CERTIFICATE OF DEATH

15737

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Silver Spring 2 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>13537 Georgia Ave #203</u>	
3. NAME OF DECEASED (Type or print) <u>Charles R. Smith</u> First Middle Last		4. DATE OF DEATH <u>Nov. 15</u> 19 <u>67</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-18</u> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE - ADJUSTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>
13. FATHER'S NAME <u>WILLIAM ROBERT SMITH</u>		14. MOTHER'S MAIDEN NAME <u>WILLIE GREEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	17. INFORMANT <u>OLIVE E. SMITH - SEE ITEM #2</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive B.C. hemorrhage</u> DUE TO <u>Esophageal varices</u> DUE TO <u>Lalunec's cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1967</u> to <u>Nov 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 15, 1967</u> , and that death occurred at <u>7:05 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Abraham W. Davis</u>		22b. DATE SIGNED <u>11-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DAVIS</u>		22d. ADDRESS <u>1106 Spring St. S.E. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawlers Sons</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	
ADDRESS <u>5130 Wise Ave. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEMORANDUM FOR THE DIRECTOR

DATE: 10/1/71

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]



5452



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15745

CERTIFICATE OF DEATH

15739

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A A</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN lb <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital,</b>				d. STREET ADDRESS <b>219 Hanover Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frances B. SMITH</b>				4. DATE OF DEATH <b>November 22 19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1893</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Medford, Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Bresnahan</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Finnegan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>218-30-7362</b>		17. INFORMANT <b>Newport</b> Address <b>R. I. CDR R. H. Smith, 50 Everett Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage massive, basillary artery</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>330 X</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from <b>Nov. 18, 1967</b> to <b>Nov. 22, 1967</b> that (s) (we) lost saw the deceased alive on <b>Nov. 22, 1967</b> , and that death occurred at <b>1100 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Ross B. Moquin</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Cdr R. B. Moquin, USN</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons</b> ADDRESS <b>5130 Wisconsin Ave., N.W., Washington, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 4 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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DEC 1 1940

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15746

15740

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2204 Luzerne Ave.</b>				d. STREET ADDRESS <b>2204 Luzerne Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LORENZO</b> First <b>G.</b> Middle <b>SMITH</b> Last				4. DATE OF DEATH <b>NOV 10 1967</b> Month <b>NOV</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 28, 1891</b>		9. AGE (In years last birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G. A. C.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James W. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Jordan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W. W. 1</b>		16. SOCIAL SECURITY NO. <b>216-46-4428</b>		17. INFORMANT <b>Mrs. Cora Smith</b> Address <b>2204 Luzerne Ave. Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4200</b> DUE TO (b) <b>ASH-D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ASH-D</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma prostate</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-15, 1965</b> to <b>11-10, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-4, 1967</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>G. F. Sengstack M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>George F. Sengstack</b>				22d. ADDRESS <b>9241 Columbia Blvd. Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Nov 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Geo County, Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawlers Sons</b> ADDRESS <b>5130 Wisc. Ave. N. W. Wash D. C.</b>				25a. REC'D BY REGISTRAR <b>NOV 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4915 River Road</b>		d. STREET ADDRESS <b>4915 River Road</b>	
3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>MAY</b> Last <b>SOLYOM</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1884</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank A. Barbour</b>		14. MOTHER'S MAIDEN NAME <b>Mary Goodin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Phyllis Lane, Bethesda, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>62</b> , to <b>14 Nov.</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10 Nov.</b> , 19 <b>67</b> , and that death occurred at <b>8:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Maesimund B. Panos, M.D.</b>		22b. DATE SIGNED <b>14 Nov 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Maesimund B. Panos, M. D.</b>		22d. ADDRESS <b>1726 Eye St., N. W., Suite 513-20006</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>11/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Md.</b>	
24. FUNERAL DIRECTOR <b>Jos. Gawler's Sons, Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1973

OFFICE OF THE COMMISSIONER OF THE DISTRICT OF COLUMBIA

1973

TO THE HONORABLE COMMISSIONER OF THE DISTRICT OF COLUMBIA  
FROM THE HONORABLE COMMISSIONER OF THE DISTRICT OF COLUMBIA  
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15742

15742

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>DOA</u>				d. STREET ADDRESS <u>621 Azalia Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kenneth C</u> Middle <u>Shaner</u> Last <u>Shaner</u>				4. DATE OF DEATH <u>Nov. 30</u> 19 <u>67</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/14/99</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Account Investigation</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>CAB</u>				13. FATHER'S NAME <u>James H. SONNER</u>			
14. MOTHER'S MAIDEN NAME <u>Ada M. Cooney</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>World Army</u>			
16. SOCIAL SECURITY NO. <u>151-07-4105A</u>				17. INFORMANT <u>Stephen Shaner (Son)</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Insufficiency, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>50 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/30/67</u>				22. DATE SIGNED			
Address (Street, city, town, or county) <u>MONTG. Co., MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>12/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 5130 WIS. AVE, NW, WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John G. Ball</u>	

25

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15749

17374

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>XXXXXX</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital 9119 MANCHESTER RD.</b>				d. STREET ADDRESS <b>9119 MANCHESTER RD</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>(NMN)</b> Last <b>SPANGENBERG</b>				4. DATE OF DEATH Month <b>11</b> Day <b>30</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 1, 1898</b>		9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manufacturers Rep.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dwight D. Inc.</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn New York</b>	
13. FATHER'S NAME <b>Frederick Spangenberg</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Frolick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W.W.I</b>				16. SOCIAL SECURITY NO. <b>577-05-3017</b>		17. INFORMANT Address <b>Walter Spangenberg 7902 Falstaff Rd. Jk. McLean Va</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency 4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.				22. DATE SIGNED <b>Nov. 30, 1967</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				DEPUTY MEDICAL EXAMINER <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Dec. 1, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>John B. Thompson &amp; Son, Inc. 8434 Georgia Ave. Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15750 CERTIFICATE OF DEATH 15743

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>120 E St. NE</u> 47-3 d. STREET ADDRESS <u>5315-Connecticut Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>FRANCES</u> Last <u>Spaulding</u>			4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1903</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>19</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mdss.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edward Pitchard</u>				
14. MOTHER'S MAIDEN NAME <u>Annie Kidney Pitchard</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>4200</u>			17. INFORMANT Address <u>Mrs. Pearl Buchanan</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>10 years</u> <u>15 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia Secondary, Nutritional - 1 year &amp; Polyarthritides 30 yrs</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>October 23, 1967</u> , to <u>Nov. 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 17, 1967</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Walcutt W. Gibson</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>November 19, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson</u>			22d. ADDRESS <u>4300 St. Barnabas Road Marlow Heights, Maryland 20031</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
23d. LOCATION (City, town or county) <u>Suitland, Md.</u>		23e. ADDRESS <u>5130 Wisconsin Ave. NW Wash. D.C. 20016</u>		23f. REC'D BY REGISTRAR <u>NOV 24 1967</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1974

STATE OF OHIO

1974



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15751

CERTIFICATE OF DEATH

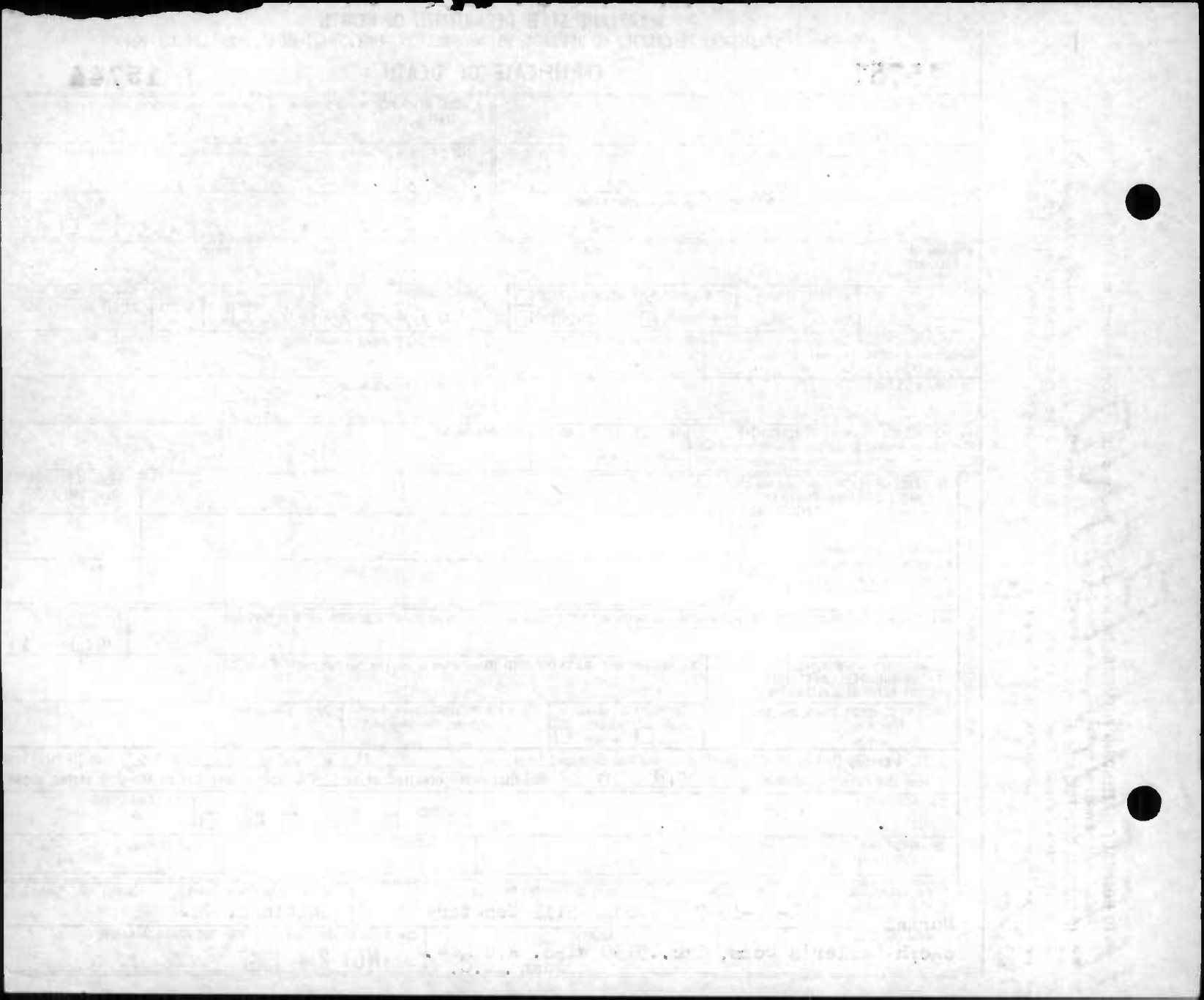
15744

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>4MO - 24 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FAIRLAND NURSING HOME 2101 FAIRLAND</u>				d. STREET ADDRESS <u>4904 CRESCENT STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>O</u> Last <u>SPORI</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1890</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction / Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHICAGO, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Jacob Spori</u>				14. MOTHER'S MAIDEN NAME <u>Anna Barbara Segasman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>579-07-0730</u>		17. INFORMANT <u>Bertha L. Spori-3050 R St. N.W.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>66</u> , to <u>NOVEMBER 19 67</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>				22d. ADDRESS <u>4115 Colie Dr. Wheaton, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				ADDRESS <u>5130 Wisconsin Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>NOV 24 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Duggan</u>			

12784

UNIVERSITY OF CALIFORNIA

12784



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film G395 12/12/67 KK  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN TB <b>12 days</b>		d. STREET ADDRESS <b>306 Marvin Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>STEELE</b> Last <b>STEELE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1873</b>
9. AGE (In years lost birthday) <b>93 1/4</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Disbursing Officer U.S. Navy Dept.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Alexander Steele</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Gallaher</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes, Spanish American WWI</b>	
16. SOCIAL SECURITY NO. <b>220 44 47 81</b>		17. INFORMANT <b>Silver Spring Md. Road</b> <b>Mrs. Charlotte Donnan, 306 Marvin Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 13, 1967</b> , to <b>Nov. 25, 1967</b> , that (I)(we) last saw the deceased alive on <b>Nov. 25, 1967</b> , and that death occurred at <b>350PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James L. Snyder</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>Nov. 27, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>James L. Snyder, M.D.</b>			22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>W. E. Pumphrey Funeral Home</b> <b>8434 Georgia Ave., Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John B. Thomas</b>

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15753

## CERTIFICATE OF DEATH

15746

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. LENGTH OF STAY in 1b <u>NE WASHINGTON DC 47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNIVERSITY NURSING HOME</u>		d. STREET ADDRESS <u>5530 CHILLUM PL.</u>	
3. NAME OF DECEASED (Type or print) First <u>ST</u> Middle <u>JAMES</u> Last <u>STEVENS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/02</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>579-54-9014</u>	
17. INFORMANT <u>Dorothy Johnson</u>		Address <u>5530 Chillum</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia</u> <u>355X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral atrophy</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23</u> , 19 <u>67</u> , to <u>Nov 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 16</u> , 19 <u>67</u> , and that death occurred at <u>15A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Myron L. Lenkan</u>		22b. DATE SIGNED <u>11/17/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park Maryland</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Stewart Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15798

STATE OF TEXAS

15798

IN SENATE,  
January 10, 1901.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1900.  
PUBLISHED BY THE  
GOVERNMENT PRINTING OFFICE,  
WASHINGTON, D. C.,  
1901.

RECEIVED  
JAN 11 1901  
U. S. DEPT. OF AGRICULTURE  
BUREAU OF LAND MANAGEMENT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

15754

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

15747

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>611 Janneys Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth</b> First <b>Speicher</b> Middle <b>STIRLING</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22 1909</b>
9. AGE (In years last birthday) <b>68 57</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>57</b> Hours <b>57</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accident, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry M. Speicher</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Gnegy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>224 58 6475</b>	
17. INFORMANT <b>Alexandria</b>		Address <b>Virginia</b> <b>Mr. James Sterling, 611 Janneys Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X Massive Cerebral Infarction</b> DUE TO (b) <b>Left mitral thrombosis</b> DUE TO (c) <b>mitral stenosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (If this hospital) attended the deceased from <b>Nov. 8, 1967</b> , to <b>Nov. 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 14, 1967</b> , and that death occurred at <b>110PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>L. W. Raymond</i>		22b. DATE SIGNED <b>Nov. 15, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. W. Raymond</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-17-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Everly-Wheatley Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				
c. LENGTH OF STAY IN 1b <u>22 days</u>					151				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>6315 Poe Road</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Constance</u> Middle <u>Stopper</u> Last <u></u>					4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1967</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-81</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>			12. CHIEF OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u> <u>Kuehner</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Daughter</u> Address <u>Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biliary cirrhosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intrinsic obstruction, common bile duct</u> DUE TO (c) <u>Biliary calculi</u>									INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uremia due to bilateral pyonephrosis.</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>67</u> to <u>Nov 10</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Nov 10</u> 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Robert N. Coale</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 10, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>			22d. ADDRESS <u>4429 Bradley Lane, Chevy Chase Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>			23d. LOCATION (City or town) (County) (State) <u>Philadelphia, Penna.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

1755

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CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15749

15756

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>			d. STREET ADDRESS <u>1202 Ednor Road</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			15-1		
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Vernon</u> Last <u>Strand</u>			4. DATE OF DEATH Month <u>November</u> Day <u>7th</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 7, 1945</u>		9. AGE (In years lost birthday) <u>22</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SP-4-E-4</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>California</u>	
13. FATHER'S NAME <u>Henry Vernon Strand</u>			14. MOTHER'S MAIDEN NAME <u>Alma Conrad</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wgt or dates of service) <u>Yes</u> <u>Apr. 4, '66-'67</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry V. Strand</u> Address <u>1202 Ednor Lane Ednor, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple extreme Injuries</u> DUE TO (b) <u>including fractured skull.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2234					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II if from fall, etc.) <u>Deceased, alone, ran off road and struck tree demolishing auto.</u>			
20c. TIME OF INJURY Month, Day, Year <u>25 Nov 7 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street Silver Spring, Md.</u>	
20f. (City or town) (County) (State) <u>Silver Spring Montgomery Md</u>					
21. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Beldon R. Reap</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Beldon Reap M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				Address (Street, City or town or county) <u>Takoma Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
23d. FUNERAL DIRECTOR <u>C. Glen Carter</u>		ADDRESS <u>Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Arlington, Va.</u>	
25a. REC'D BY REGISTRAR <u>NOV 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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WILLIAM L. BARNETT, CATHOLIC

WILLIAM L. BARNETT, CATHOLIC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2—should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15757		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		15750	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home Wheaton</u> <u>401 Randolph Rd Wheaton</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>11506 ALMA street.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DOROTHY FARR TALBOT</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18-10-89</u>	9. AGE (In years lost birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON DC.</u>	
13. FATHER'S NAME <u>MCCARTHY FARR</u>		14. MOTHER'S MAIDEN NAME <u>EMMA BELLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-18-7589 A</u>		17. INFORMANT Address <u>Same as</u> <u>Mrs. Dorothy Buckler, Daughter #2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>67</u> , to <u>11/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>67</u> , and that death occurred at <u>1p</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Myron L. Lenken</u>		22b. DATE SIGNED <u>11/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Myron L. Lenken, M. D.</u>	
22d. ADDRESS <u>2390 Glenmont Cir, Wheaton Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Wash., D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MONTGOMERY</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="float: right;">Virginia</span> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN Ib 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 8415 Stonewall Drive			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First</span> <span style="float: right;">Middle</span> <span style="float: right;">Last</span> Jane Eaton TATE				<b>4. DATE OF DEATH</b> Month <span style="float: right;">November</span> <span style="float: right;">Day</span> <span style="float: right;">Year</span> 16 19 67			
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> Cauc	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> March 29, 1925		<b>9. AGE</b> (In years last birthday) 42 yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> N/A		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Norton, Virginia			
<b>13. FATHER'S NAME</b> Harry Eaton				<b>14. MOTHER'S MAIDEN NAME</b> Carmen O'Conner			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 406-24-3328		<b>17. INFORMANT</b> <span style="float: right;">Address</span> Drive, Vienna Va. Capt. Benjamin Tate, USN, 8415 Stonewall			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="float: right;">163 X</span> DUE TO <span style="float: right;">metastasis</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <span style="float: right;">19</span> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (H) (this hospital) attended the deceased from</b> <u>Oct. 20, 1967</u> , <b>to</b> <u>Nov. 16, 1967</u> , <b>that (H) (we) last saw the deceased alive on</b> <u>Nov. 16, 1967</u> , <b>and that death occurred at</b> <u>6:20 P.</u> , <b>from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> Lawrence W. Raymond			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> Nov. 17, 1967		
<b>22c. PHYSICIAN'S NAME (Type)</b> Lawrence W. Raymond			<b>22d. ADDRESS</b> Naval Hospital, Bethesda, Md.				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE THEREOF</b> 11/21/67		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Arlington National			
<b>23d. LOCATION (City or Town)</b> Arlington, Va.		<b>(County)</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> Money & King Funeral Home 171 Maple Ave., West, Vienna, Virginia				<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 20 1967</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15759

CERTIFICATE OF DEATH

15752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN <u>14 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				16-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2817-Nicholson St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sterling</u> Middle <u>Otis</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foreman</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Parrell Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris C. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Fannie E. Ebaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Glen Taylor, 7 Orchard Ave.</u>		Address <u>Newark Del.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>MYOCARDIAL INFARCTION.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1</u> <u>2 weeks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , <u>1959</u> , to <u>Nov 22</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov 21</u> , 1967, and that death occurred at <u>6 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert B. Irey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>				22d. ADDRESS <u>11161 New Hampshire Ave., S.S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>COLUMBIA MARJOR, P.G.C. Md.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				ADDRESS <u>300 - 4th St. N.E.</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15753

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Senesca</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>24 Westwood Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Thompson</u>		4. DATE OF DEATH <u>11-29</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-22</u>
9. AGE (In years lost birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Electric Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Georgie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wpr or dates of service) <u>Yes W.W.II</u>		16. SOCIAL SECURITY NO. <u>Wife - Ex-13</u>	
17. INFORMANT <u>Wife - Ex-13</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatitis</u> DUE TO (b) <u>5870</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty cirrhosis (Metamorphosis) liver, marked.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>67</u> , to <u>11/29/67</u> , that (I) (we) last saw the deceased alive on <u>11/29/67</u> 19 <u>67</u> , and that death occurred at <u>2:00 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick Caldwell</u>		22b. DATE SIGNED <u>11/29/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>Dec. 3, 1967</u>	<u>John Wesley Cemetery</u>	<u>Clarksburg Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert H. Snowden</u>		25a. REC'D BY REGISTRAR <u>DEC 6 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G395 11/27/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mong.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		d. STREET ADDRESS <u>930 Veirs Mill Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>930 Veirs Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leland</u> First <u>H.</u> Middle <u>True</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry True</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fellows</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>376 36 0910</u>	
17. INFORMANT <u>Lillian L. True</u>		Address (Same as Above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ISCHEMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR DISEASE</u> DUE TO (c) <u>SEVERE RHEUMATOID ARTHRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>5 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE RHEUMATOID ARTHRITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>19 NOV</u> , 19 <u>67</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>9 NOV</u> , 19 <u>67</u> , and that death occurred at <u>4:55 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S Caldwell</u> M.D.		22b. DATE SIGNED <u>11-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u>		22d. ADDRESS <u>ROCKVILLE MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jones Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Jackson Mich.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

13732

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

STATEMENT OF WORK

DATE: 10-1-1964

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a detailed statement of work or contract description.]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		d. STREET ADDRESS <b>11200 Lockwood Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Louis TURKOFF</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/04</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Morris Turkoff</b>		14. MOTHER'S MAIDEN NAME <b>Anna Zisselman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-18-0696</b>	
17. INFORMANT <b>Irving Turkoff</b>		Address <b>11119 Stillwater Ave., Kensington, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b>		22. DATE SIGNED <b>Nov. 28, 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		Address (City or town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Va.</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home 4217 9th St., N.W.</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15763

**CERTIFICATE OF DEATH**

15756

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> <span style="float:right">23-3</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval</b>				d. STREET ADDRESS <b>4241 South 35th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward A. WAGNER</b> First Middle Last				4. DATE OF DEATH <b>November 22</b> 19 <b>67</b> Month Day Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 Jan 1899</b>		9. AGE (In years lost birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy (ret)</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Catasagua, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William WAGNER</b>				14. MOTHER'S MAIDEN NAME <b>Laurine BARTHOIMEW</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>578-12-5722</b>		17. INFORMANT <b>Mrs. Helen T. WAGNER</b> Address <b>4241 South 35th Street Arlington, Virginia</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Stomach with massive</b> <b>151X</b> DUE TO <b>Metastasis to the Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (his hospital) attended the deceased from <b>2 November, 1967</b> to <b>22 November 1967</b> , that (X) (we) lost saw the deceased alive on <b>22 November 1967</b> , and that death occurred at <b>1000A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Donald K. Roeder</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>23 Nov 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Donald K. ROEDER, LCDR MC USN</b>				22d. ADDRESS <b>Naval Hospital, NNMC, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>27 Nov. 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>			
24. FUNERAL DIRECTOR <b>EVERLY-WHEATLEY Alexandria, Virginia</b>				25a. RECEIVED BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <i>James George</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

33721

REPUBLIC OF CHINA

1953



*[Faint, mostly illegible text and markings covering the main body of the document, possibly representing a ledger or form.]*

*[Faint vertical text or markings along the right margin, possibly a date or reference code.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
15757										
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA					c. LENGTH OF STAY IN 1b 10 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD WALDMAN					4. DATE OF DEATH Month Day Year Nov 22 19 67					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/21/08		9. AGE (In years lost birthday) 59 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY NORELCO SVS.		11. BIRTHPLACE (County & State, or foreign country) PENNA			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JULIUS WALDMAN					14. MOTHER'S MAIDEN NAME FRANCES KIRSCHENBAUM					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO.		17. INFORMANT FLORENCE WALDMAN - WIFE SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Cardiac arrest & pulmonary edema DUE TO (b) acute myocardial infarction DUE TO (c) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 16 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, obesity								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12:30 PM Nov 20, 1967 to 12:30 PM Nov 22, 1967, that (I) (we) saw the deceased alive on Nov 19, 1967, and that death occurred at 12:30 PM, from causes and on the date stated above.										
22a. SIGNATURE Sidney J. Malauer					22b. DATE SIGNED Nov 22, 1967			22c. ADDRESS 8218 Wisconsin Ave, Bethesda, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11/26/67		23c. NAME OF CEMETERY OR CREMATORY New Montefiore Cem.		23d. LOCATION (City or Town) (County) (State) Hollis, L.I. N.Y.	
24. FUNERAL DIRECTOR B. Dargatzis & Sons					25a. REC'D BY REGISTRAR DATE NOV 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

12/23

STAGE 10 - 11/11/11

12/23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15765

15758

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>16 days</u>		d. STREET ADDRESS <u>5306 Carvel Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alan</u> Middle <u>Tower</u> Last <u>Waterman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 June 1892</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scientist</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank A. Waterman</u>		14. MOTHER'S MAIDEN NAME <u>Florence Tower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Multiple Gastric Stress Ulcers</u> DUE TO (c) <u>Post-Operative bile Peritonitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>2 Weeks</u> <u>3 Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 14, 1967</u> , to <u>Nov. 30, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 30, 1967</u> , and that death occurred at <u>6:00 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Ralph</u>		22b. DATE SIGNED <u>12/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Ralph, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Dec. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, P.G.'s Md.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Co. 2901-14th St. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>

8258

8258

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides recommendations for future research. The references list the sources of information used in the study.



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15759

15765

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Lewisdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Noe Nursing Home</b>		d. STREET ADDRESS <b>RFD # 1, Monrovia</b>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ann</b> Last <b>Watkins</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1877</b>
9. AGE (In years lost birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cedar Grove, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Burdette</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Watkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Ada Watkins, Item 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Terminal Broncho-pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Arteriosclerotic Cardiovascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No injury</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>was not</del> attended the deceased from <b>1935</b> , 19____, to <b>November 29, 19 67</b> , that (I) <del>was</del> last saw the deceased alive on <b>November 27, 19 67</b> , and that death occurred at <b>10:37 P.M.</b> at <b>Monrovia</b> and on the date stated above.			
22a. SIGNATURE <b>M. McKendree Boyer, M.D.</b>		22b. DATE SIGNED <b>November 30, 19 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M.D.</b>		22d. ADDRESS <b>9701 Church Street, Damascus, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b>	23d. LOCATION (City or Town) (County) (State) <b>Browningsville, Md.</b>
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15767

15760

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Rest Home</u>		d. STREET ADDRESS <u>5709 43rd Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELISABETH</u> Middle <u>W.</u> Last <u>WEAVER</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse H. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Woodward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>276 30 1004</u>	
17. INFORMANT <u>Frank L. Weaver Same as #2 (husband)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arterial Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20, 1967</u> , to <u>Nov. 13, 1967</u> that (I) <del>(we)</del> last saw the deceased alive on <u>Nov. 13, 1967</u> , and that death occurred at <u>9a</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE SIGNED <u>Nov. 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, M.D.</u>		22d. ADDRESS <u>6911 5th &amp; Hw Wk DC 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15768

15761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>			
c. LENGTH OF STAY IN 1b <u>1 month</u>				d. STREET ADDRESS <u>11227 OLD BALTIMORE PIKE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Landy</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOW</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-94</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESEARCH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John Wells</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Lee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>CHART</u>		17. INFORMANT <u>Washington Sanitarium &amp; Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Urinary Bladder</u> <u>1810</u> DUE TO <u>with metastasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>10-13</u> , 19 <u>67</u> , to <u>11-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-12</u> , 19 <u>67</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>11/13/67</u>		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>				25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
25c. LOCATION (City or Town) (County) (State) <u>Hyattsville, Md.</u>				25d. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12751

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15762											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - BURTNSVILLE</b> c. LENGTH OF STAY IN 1b <b>3 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LIPPARD NURSING HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. STREET ADDRESS <b>6309 Landon Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Therese First Middle Last</b> <b>THERESA GERTRUDE WESCHLER</b>						4. DATE OF DEATH Month <b>Nov.</b> Day <b>8</b> Year <b>1967</b>					
5. SEX <b>FEM.</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 21, 1887</b>		9. AGE (in years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLEMENT KROGMANN</b>						14. MOTHER'S MAIDEN NAME <b>Mary M. LOCK BOEHLER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>- - -</b>				16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFIRMANT <b>MRS. ANNA L. RUPPERT - 5420 CONN. AVE. NW</b>				Address <b>WASH. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma from</b> <b>170X</b> DUE TO <b>Breast - widespread to bone</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>and Lungs</b> (c) <b>and Lungs</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute + Chronic Hemorrhagic cystitis</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8/19</b> , 19 <b>67</b> , to <b>11/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/27</b> , 19 <b>67</b> , and that death occurred at <b>2:30</b> PM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Joseph E. Smith, Jr.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Smith, Jr. M.D.</b>						22d. ADDRESS <b>Burtensville, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-11-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Oliver, Cemeter</b>				23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>						ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15770

**CERTIFICATE OF DEATH**

15763

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)			
a. COUNTY <b>Montgomery</b>		MARYLAND		o. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>				d. STREET ADDRESS <b>9525 Linden Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>DAISY I. WHITON</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Nov. 9, 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/15/81</b>	
9. AGE (In years lost birthday) yrs. <b>86</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Atlanta, Ga.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>220-44-9180</b>				17. INFORMANT <b>4641 Montgomery Ave. Bethesda, Md. Mr. Archie Meatyard-Lawyer- 20014</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X DEHYDRATION &amp; ACIDOSIS</b> DUE TO (b) <b>LOWER BOWEL OBSTRUCTION</b> DUE TO (c) <b>CARCINOMA (RECTAL)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>1 WEEK</b> <b>1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY</b> , 19 <b>67</b> , to <b>NOV. 10</b> , 19 <b>67</b> , that (I) <b>(ame)</b> lost the deceased alive on <b>NOV. 9, 1967</b> , and that death occurred at <b>7:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Joseph J. Connor</b>				22b. DATE SIGNED <b>11/9/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Joseph J. Connor</b>	
22d. ADDRESS <b>9420 Old Georgetown Rd., Bethesda, Md</b>				22e. ADDRESS <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN lb <u>1 mo 22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3333 University Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>James T WILLETT</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>Nov 11 1967</u> Month Day Year		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2-3-1900</u> <b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>			<b>13. FATHER'S NAME</b> <u>William Willett</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Kane</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes give War or dates of service) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <u>216-44-9339</u> <b>17. INFORMANT</b> <u>Wife</u> Address <u>Same as Item 2.</u> <u>Helene Willett</u>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5811 Hypertension</u> DUE TO (b) <u>Liver Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Laennec's Cirrhosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 1967</u> <b>to</b> <u>Nov 11, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Nov 7 1967</u> , <b>and that death occurred at</b> <u>12:05</u> <b>PM</b> , <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Robert T. Thibadeau</u>			<b>22b. DATE SIGNED</b> <u>11-11-67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert T. Thibadeau</u> <b>22d. ADDRESS</b> <u>11,000 Old Gerogetown Road</u> <u>Rockville Maryland 20852</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>11-15-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Natl Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>		
<b>24. FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 14 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

15772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15765

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASH. D.C.</b> b. COUNTY <b>47-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM HOSP.</b>		d. STREET ADDRESS <b>1436 OCLETHORPE ST. N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRIETT B. (MADE) WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>Nov. 14 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-02</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WM. BALDTHANN</b>	
14. MOTHER'S MAIDEN NAME <b>Julia M. Elliott</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>577-09-8859</b>		17. INFORMANT <b>(HUSBAND) WARREN WILLIAMS</b> Address <b>SADIE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure secondary to</b> (c) <b>hypertension, atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11/8/67</b> <b>11/14/67</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-8</b> , 19 <b>67</b> , to <b>11-14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>6:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Chas H. Wolston</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Chas H. Wolston</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-17-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NAT. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND MARYLAND</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons 5 Bollinger Ave.</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

14182

INSTITUTE OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
15773 15766									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 1b <u>43 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> 15-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>					d. STREET ADDRESS <u>2806 Radius Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis I. Wood</u>					4. DATE OF DEATH Month Day Year <u>11 1 19 67</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>7-24-14</u>		9. AGE (In years lost birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Supervisor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis J. Wood</u>					14. MOTHER'S MAIDEN NAME <u>Catherine O'Neil</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>578-40-3723</u>		17. INFORMANT <u>John Wood</u> Address <u>7403 Buchanan Street Hyattsville, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of nasopharynx &amp; retropharynx</u> 146X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>11-1-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-1</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes on and on the date stated above.									
22a. SIGNATURE <u>Morris Perry</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>					22d. ADDRESS <u>11602 Georgia Avenue, Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR <u>C. Glen Carter 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR <u>DATE NOV 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in lb <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>75 East Wayne Ave., #505</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELDA RUTH WOOD</b>		4. DATE OF DEATH Month Day Year <b>November 15 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-29</b>
9. AGE (In years lost birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Counselor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Suburban Personnel</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>A.J. Norton</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Sparks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. James F. Wood, Husband</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure due</b> <b>9702</b> DUE TO <b>to Barbiturate Intoxication</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Deceased took overdose of Nembutal Capsules</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased took overdose of Nembutal Capsules</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11-15-67 19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Motel</b>	20f. (City or town) (County) (State) <b>Silver Spring Montgomery MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		22. DATE SIGNED <b>11/15/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>11/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County Md.</b>
24. FUNERAL DIRECTOR <b>C. Glen Carter</b> <b>Warner E. Pumphrey Inc.</b>		ADDRESS <b>Silver Spring</b> <b>8434 Georgia Ave.</b>	25a. REC'D BY REGISTRAR <b>NOV 22 1967</b> DATE
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15775

15768

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY in 1b <u>1-Month.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>SILVER SPRING</del> <u>Wheaton</u> d. STREET ADDRESS <u>2374 GLENMONT CIRCLE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CALVIN Eugene</u> <u>WRIGHT</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>11</u> - <u>14</u> 19 <u>67</u>				
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-1-14</u>	<b>9. AGE</b> (In years last birthday) <u>53</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PLUMBER Self Employed</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self Employed</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>VA.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			<b>13. FATHER'S NAME</b> <u>Burrell W. Wright</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Una Lea Wright</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>yes</u>		<b>17. INFORMANT</b> <u>Edith Mae Wright</u> <u>2374 Glenmont Circle Wheaton, Md.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X CONGESTIVE HEART FAILURE</u> DUE TO <u>PULMONARY INFARCTS. CHRONIC ATRIAL FIBRILLATION.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RHEUMATIC HEART DISEASE</u> <u>MITRAL + AORTIC STENOSIS</u> DUE TO (c) <u>STROKE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>RENAL INSUFFICIENCY</u> <u>PULMONARY INSUFFICIENCY</u> <u>PULMONARY EMPHYSEMA</u> <u>FIBROSIS</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 weeks.</u> <u>36 years.</u> <u>As above.</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August</u> , 19 <u>67</u> , <b>to</b> <u>November 14</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>November 14</u> , 19 <u>67</u> , <b>and that death occurred at</b> <u>11 P.</u> M, <b>from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Hugo G. Graziani</u>			<b>22b. DATE SIGNED</b> <u>11/14/67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>HUGO G. GRAZIANI, MD.</u>		
<b>22d. ADDRESS</b> <u>10101 GEORGIA AVE, SILVER SPRING, MD.</u>			<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				
<b>23b. DATE THEREOF</b> <u>Nov. 18, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>		<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Prince Georges County, Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15769

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>University Nursing Home</b> <b>901 Argo Ave.</b>				d. STREET ADDRESS <b>2213 Calvert St.</b>			
3. NAME OF DECEASED (Type or print) <b>Mrs. Lula Irwin</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/9/94</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Harris Irwin</b>				14. MOTHER'S MAIDEN NAME <b>Anna Laura Key</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>577-10-4859D</b>		17. INFORMANT <b>Joan L. Yilek-2118 Beechwood Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1930 Astrocytoma of Brain</b> DUE TO (b) <b>West Hyattsville, Md.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/19/67</b> to <b>11/24/67</b> that (I) (we) last saw the deceased alive on <b>11/24/67</b> , and that death occurred at <b>10:15 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William Brain</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WM BRAIN, M</b>				22d. ADDRESS <b>6124 Central Ave Capital Hill Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b> <b>2901 14th St. N.W. Wash. D.C.</b>				25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FILE TO TABLE 7

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TO THE DIRECTOR

FROM THE DIRECTOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>8115 Springfield Village Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Cyrus</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 October 1923</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply Specialist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Young</u>		14. MOTHER'S MAIDEN NAME <u>Alvina Varin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1943-1946</u>		16. SOCIAL SECURITY NO. <u>039-05-7464</u>	
17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Encephalopathy</u> DUE TO (b) <u>Carcinoma of Pancreas with metastasis to Liver</u> DUE TO (c) <u>4 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 20</u> , 19 <u>67</u> , to <u>Nov. 16</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 16</u> , 19 <u>67</u> , and that death occurred at <u>9:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Keyes, Jr.</u>		22b. DATE SIGNED <u>17 Nov. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John W. Keyes, Jr., MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Young's Family</u>	23d. LOCATION (City or Town) (County) (State) <u>Johnston, Rhode Island</u>
24. FUNERAL DIRECTOR <u>Arnold F. Burner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 21 1967</u>	

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REMARKS OF TESTS

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VIOLET H. ZENTZ</b> Middle Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>29,</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 9, 1893</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Parochial Care Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>August Beushauser</b>				14. MOTHER'S MAIDEN NAME <b>Rose Lambs</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>394-05-9208</b>		17. INFORMANT <b>Son</b> <b>Rodney G. Zentz</b> <b>2670 Univ. Blvd., W. Wheaton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with Cardiomegaly</b> DUE TO (c) <b>Acute Pyelonephritis with Uremia</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <b>12-1-67</b>
ACTUAL SIGNATURE <b>Belden R. Reap</b> EXAMINER'S NAME (Type)		<b>BELDEN R. REAP</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Wheaton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-3-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



Director of Police

San Francisco

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